WOMEN'S CARE CENTER
9332 State Road 54
Trinity, FL. 34655
Dr. Robert Smith

PATIENT NAME: ______________________________________ **DATE:** _______________

Date of last Menstrual Period: ____________

REASON FOR VISIT: (You may only mark one reason- a problem and well woman cannot be done together)

☐ Well Women Exam ☐ Problem Visit ☐ Referral ☐ Second opinion

CHIEF COMPLAINT:
Briefly describe why you are being seen: ____
____
____

SURGICAL HISTORY

Vaginal Delivery	___Yes ___ No	LEEP	___Yes ___No
Cesarean Section	___Yes ___No	Cone Biopsy	___Yes ___No
Abdominal Hysterectomy	___Yes ___ No	Vaginal Repair	___Yes ___No
Vaginal Hysterectomy	___Yes ___ No	Appendectomy	___ Yes ___No
BSO (ovaries and tubes)	___Yes ___ No	Tonsillectomy	___ Yes ___No
Laparoscopy	___Yes ___ No	Breast Surgery	___ Yes ___No
Tubal Ligation	___Yes ___ No	Gall Bladder	___ Yes ___No
D&C	___Yes ___ No	Thyroid	___Yes ___No
Hysteroscopy	___Yes ___ No		
Ablation	___Yes ___ No		

Other ____

MEDICATIONS

List all Current Medications
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________

List ALL Drug Allergies
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________

SOCIAL HISTORY

Use of Tobacco ___Yes ___ No Number of pack per day ________ Number of Years ________
Use of Alcohol ___Yes ___No Rarely ____ Social ____ Daily ____ Heavy ____
Use of Illegal Drugs ___Yes ___No Drug ____

GYNECOLOGICAL HISTORY

Age at which periods began _______ Date of Menopause ____________
Length of Cycle (28 days) _______
Length of Period _____
Pain with Period _____ (mild, moderate, severe)
Relieved with Medication ____ Yes ____ No

Date of Last Pap ___________ Result _________ History of Abnormal Pap ___Yes ___No
Date of Last Mammography ____________ Result _________ History of Abnormal Mammo ___Yes ___No
Date of Last Bone Density ____________ Result _________

Are you currently Sexually Active ___Yes ___ No
Number of Lifetime Sex Partners __________
History of Sexually Transmitted Disease ___Yes ___ No Type _________________________
History of Pelvis Infections ___Yes ___No
Currently using Contraceptive ___Yes ___ No Name _________________________
Currently using Hormones ___Yes ___ No Name _________________________

OBSTETRICAL HISTORY

Number of Pregnancies _____________
Number of Term Deliveries _____________
Number of Preterm Deliveries (<37 weeks) _____________
Number of Miscarriages _____________
Number of Abortions _____________
Number of Tubal Pregnancies _____________
Number of Living Children _____________

PRIMARY CARE PHYSICIAN ___________________________________

DOCTOR USE

Assessment/Plan: ____
____
____
____
____

RX/LABS: ____
____
____
____